		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039321

Facility Name: Glenshire Nursing and Rehabilitation Centre

Address: 22660 South Cicero Avenue (Number) Richton Park (City) 60471 (Zip Code)

County: Will

Telephone Number: (708) 747-6120 **Fax #** (708) 747-6491

IDPA ID Number: 363939906001

Date of Initial License for Current Owners: 03/23/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Altschuler, Melvoin and Glasser LLP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed) (Date)
	(Type or Print Name)
	(Title)
Paid Preparer	(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)
	(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606-3392
	(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,972	1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,632	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	294	TOTALS	294	107,604	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	57,107	1,776	6,712	65,595	8
9	SNF/PED					9
10	ICF	23,149	355	392	23,896	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	80,256	2,131	7,104	89,491	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.17%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [X] NO [ ]
Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/94

J. Was the facility purchased or leased after January 1, 1978? YES [X] Date 03/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year? YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 5111

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	343,633	57,685	24,943	426,261		426,261	0	426,261			1
2	Food Purchase		498,923		498,923	(25,829)	473,094	(10,294)	462,800			2
3	Housekeeping	306,621	99,508		406,129		406,129	0	406,129			3
4	Laundry	171,589	9,942	30,250	211,781		211,781	0	211,781			4
5	Heat and Other Utilities			169,560	169,560		169,560	7,961	177,521			5
6	Maintenance	100,339	39,479	134,292	274,110		274,110	23,532	297,642			6
7	Other (specify):*							0				7
8	TOTAL General Services	922,182	705,537	359,045	1,986,764	(25,829)	1,960,935	21,199	1,982,134			8
	B. Health Care and Programs											
9	Medical Director			19,250	19,250		19,250	0	19,250			9
10	Nursing and Medical Records	3,260,998	752,836	304,736	4,318,570		4,318,570	(222,354)	4,096,216			10
10a	Therapy	159,806	2,952	166,270	329,028		329,028	0	329,028			10a
11	Activities	145,558	7,708	1,494	154,760		154,760	0	154,760			11
12	Social Services	68,008		5,316	73,324		73,324	0	73,324			12
13	Nurse Aide Training							0				13
14	Program Transportation			230	230		230	0	230			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	3,634,370	763,496	497,296	4,895,162		4,895,162	(222,354)	4,672,808			16
	C. General Administration											
17	Administrative	155,677		1,393,889	1,549,566		1,549,566	(1,393,889)	155,677			17
18	Directors Fees							0				18
19	Professional Services			118,358	118,358		118,358	4,163	122,521			19
20	Dues, Fees, Subscriptions & Promotions			42,723	42,723		42,723	1,826	44,549			20
21	Clerical & General Office Expenses	408,394	57,639	41,376	507,409		507,409	39,510	546,919			21
22	Employee Benefits & Payroll Taxes			753,911	753,911	25,829	779,740	56,303	836,043			22
23	Inservice Training & Education			2,158	2,158		2,158	657	2,815			23
24	Travel and Seminar							1,644	1,644			24
25	Other Admin. Staff Transportation			4,186	4,186		4,186	1,945	6,131			25
26	Insurance-Prop.Liab.Malpractice			199,415	199,415		199,415	2,222	201,637			26
27	Other (specify):*							0				27
28	TOTAL General Administration	564,071	57,639	2,556,016	3,177,726	25,829	3,203,555	(1,285,619)	1,917,936			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,120,623	1,526,672	3,412,357	10,059,652		10,059,652	(1,486,774)	8,572,878			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000 SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,199	72,199		72,199	511,655	583,854			30
31	Amortization of Pre-Op. & Org.			6,693	6,693		6,693	(6,693)				31
32	Interest							862,818	862,818			32
33	Real Estate Taxes							669,071	669,071			33
34	Rent-Facility & Grounds			2,338,300	2,338,300		2,338,300	(2,338,300)				34
35	Rent-Equipment & Vehicles			11,022	11,022		11,022	9,902	20,924			35
36	Other (specify):*							59,329	59,329			36
37	**TOTAL Ownership**			2,428,214	2,428,214		2,428,214	(232,218)	2,195,996			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		283,268	16,817	300,085		300,085	0	300,085			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			160,968	160,968		160,968	0	160,968			42
43	Other (specify):* Non-Allowable			387,793	387,793		387,793	(387,793)				43
44	**TOTAL Special Cost Centers**		283,268	565,578	848,846		848,846	(387,793)	461,053			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,120,623	1,809,940	6,406,149	13,336,712	0	13,336,712	(2,106,785)	11,229,927			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(54,683)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(752)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(38,250)	43		18
19	Entertainment	(629)	43		19
20	Contributions	(3,350)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(334,782)	43		24
25	Fund Raising, Advertising and Promotional	(2,068)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,273)	43		28
29	Other-Attach Schedule See Attached Schedule F	(251,415)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (693,202)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(6,693)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,406,890)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (1,413,583)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (2,106,785)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X	89,248	Ln 39	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$ 89,248		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Detail lines 29 and 35 of Page 9 starting in B44. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page-5A**

Facility Name: Glenwood Rehabilitation Center

No: 082012

Report Period Beginning: 1/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
The information listed in B13 thru G43 is from Page 5.		
1 **Day Care**	0	0
2 **Other Care for Outpatients**	0	0
3 **Governmental Sponsored Special Programs**	0	0
4 **Non-Patient Meals**	0	0
5 **Telephone, TV & Radio in Resident Rooms**	0	0
6 **Rented Facility Space**	0	0
7 **Sale of Supplies to Non-Patients**	0	0
8 **Laundry for Non-Patients**	0	0
9 **Non-Straight-line Depreciation**	0	0
10 **Interest and Other Investment Income**	(54,683)	32
11 **Discounts, Allowances, Rebates & Refunds**	0	0
12 **Non-Working Officer's or Owner's Salary**	0	0
13 **Sales Tax**	(752)	43
14 **Non-Care Related Interest**	0	0
15 **Non-Care Related Owner's Transactions**	0	0
16 **Personal Expenses (Including Transportation)**	0	0
17 **Non-Care Related Fees**	0	0
18 **Fines and Penalties**	(8,250)	43
19 **Entertainment**	(629)	43
20 **Contributions**	(1,350)	43
21 **Owner or Key Man Insurance**	0	0
22 **Special Legal Fees & Legal Retainers**	0	0
23 **Life Insurance Insurance for Individuals**	0	0
24 **Bad Debt**	(334,782)	43
25 **Fund Raising, Advertising and Promotional**	(2,068)	43
26 **Income & IL Personal Property Replacement Taxes**	0	0
27 **Nurse Aide Training for Non-Employees**	0	0
28 **Yellow Page Advertising**	(7,273)	43
29 **Non-Paid Workers**	0	0
30 **Donated Goods**	0	0
31 **Amortization Expense**	(6,495)	31
32 Adj. Management Comp. Medical Supplies' 'A' To Cost	(98,705)	10
33 Adj. Management Comp. Medical Supplies' Other' To Cost	(27,669)	10
34 Adj. Management Comp. Food To Cost	(10,294)	2
35 Amortization of Current Year Deferred Maintenance	14,065	6
36 Non-allowable Professional Fees	(27,669)	19
37 Defer 2000 Painting and Decorating	(5,094)	6
38 Patient Clothing	(689)	43
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Sch V Line	Adj. Summary
Line 1	0
Line 2	(10,994)
Line 3	0
Line 4	0
Line 5	0
Line 6	9307
Line 7	0
Line 8	(1,702)
Line 9	0
Line 10	(222,954)
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	(27,669)
Line 17	0
Line 18	0
Line 19	(27,669)
Line 20	0
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	0
Line 28	(27,669)
Line 29	(265,714)
Line 30	0
Line 31	8,955
Line 32	(54,988)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(61,307)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	(367,932)
Line 44	(367,932)
Line 45	(664,647)

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure not to highlight rows 45 thru 62.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,294)	0	0	0	0	0	0	0	0	0	0	(10,294)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	7,961	0	0	0	0	0	0	0	0	7,961	5
6	Maintenance	8,971	0	14,561	0	0	0	0	0	0	0	0	23,532	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,323)	0	22,522	0	0	0	0	0	0	0	0	21,199	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(222,354)	0	0	0	0	0	0	0	0	0	0	(222,354)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(222,354)	0	0	0	0	0	0	0	0	0	0	(222,354)	16
	C. General Administration													
17	Administrative	0	0	(331,389)	(1,062,500)	0	0	0	0	0	0	0	(1,393,889)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(27,049)	0	30,212	0	1,000	0	0	0	0	0	0	4,163	19
20	Fees, Subscriptions & Promotions	0	0	1,826	0	0	0	0	0	0	0	0	1,826	20
21	Clerical & General Office Expenses	0	0	38,439	0	1,071	0	0	0	0	0	0	39,510	21
22	Employee Benefits & Payroll Taxes	0	0	56,303	0	0	0	0	0	0	0	0	56,303	22
23	Inservice Training & Education	0	0	657	0	0	0	0	0	0	0	0	657	23
24	Travel and Seminar	0	0	1,644	0	0	0	0	0	0	0	0	1,644	24
25	Other Admin. Staff Transportation	0	0	1,945	0	0	0	0	0	0	0	0	1,945	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,222	0	0	0	0	0	0	0	0	2,222	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(27,049)	0	(198,141)	(1,062,500)	2,071	0	0	0	0	0	0	(1,285,619)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(250,726)	0	(175,619)	(1,062,500)	2,071	0	0	0	0	0	0	(1,486,774)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	31,319	0	480,336	0	0	0	0	0	0	511,655	30
31	Amortization of Pre-Op. & Org.	(6,693)	0	0	0	0	0	0	0	0	0	0	(6,693)	31
32	Interest	(54,683)	0	33,691	0	883,810	0	0	0	0	0	0	862,818	32
33	Real Estate Taxes	0	0	11,961	0	657,110	0	0	0	0	0	0	669,071	33
34	Rent-Facility & Grounds	0	0	0	0	(2,338,300)	0	0	0	0	0	0	(2,338,300)	34
35	Rent-Equipment & Vehicles	0	0	9,902	0	0	0	0	0	0	0	0	9,902	35
36	Other (specify):*	0	0	0	0	59,329	0	0	0	0	0	0	59,329	36
37	**TOTAL Ownership**	(61,376)	0	86,873	0	(257,715)	0	0	0	0	0	0	(232,218)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(387,793)	0	0	0	0	0	0	0	0	0	0	(387,793)	43
44	**TOTAL Special Cost Centers**	(387,793)	0	0	0	0	0	0	0	0	0	0	(387,793)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(699,895)	0	(88,746)	(1,062,500)	(255,644)	0	0	0	0	0	0	(2,106,785)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: Glenshire Nursing and Rehabilitation Centre — # 0039221 — Report Period Beginning: 1/01/2008 — Ending: 12/31/2008

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sidney Glesner	80.00 %	GlenBridge Nursing & Rehabilitation Centre,Ltd	Niles	SEE ATTACHED SCHEDULE A		
Barry Ray	20.00 %	GlenCrest Nursing & Rehabilitation Centre,Ltd	Chicago			
		Glen Elkton Nursing & Rehabilitation Centre,Ltd	Chicago			
		Glen Oaks Nursing & Rehabilitation Centre,Ltd	Northbrook			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization: Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V							1	
2	V	Total from Page 6A	321,389	Glen Health and Home Management, Inc.	A	243,643	(88,746)	2	-88746
3	V							3	
4	V	Total from Page 6B	1,062,500	GlenBar Management Company, Ltd.	B	0	(1,062,500)	4	-1062500
5	V							5	
6	V	Total from Page 6C	2,339,200	GlenNiles Real Estate and Development Limited Partnership	C	2,082,456	(256,644)	6	-255644
7	V							7	
8	V							8	
9	V			OWNERSHIP REFERENCE:				9	
10	V			A: Owned 41.50 % by Sidney Glesner				10	
11	V			B: Owned 80.00 % by Sidney Glesner & 20.00 % by Barry Ray				11	
12	V			C: Owned 48.00 % (contractively) by Sidney Glesner & 20.00 % by Barry Ray				12	
13	V							13	
14	Total		3,723,089			2,325,399	(1,406,890)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPOR

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	17	Management Fees	$ 331,389	Glen Health and Home Management, Inc.	A	$	$ (331,389)	15	-331389
16	V	5	Utilities		Glen Health and Home Management, Inc.	A	7,961	7,961	16	7961
17	V	6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	14,561	14,561	17	14561
18	V	19	Professional Fees		Glen Health and Home Management, Inc.	A	30,212	30,212	18	30212
19	V	20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	1,826	1,826	19	1826
20	V	21	Clerical		Glen Health and Home Management, Inc.	A	38,439	38,439	20	38439
21	V	22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	56,303	56,303	21	56303
22	V	23	Training and Education		Glen Health and Home Management, Inc.	A	657	657	22	657
23	V	32	Amortization of Mortgage Cost		Glen Health and Home Management, Inc.	A	351	351	23	351
24	V	25	Auto Expenses		Glen Health and Home Management, Inc.	A	1,945	1,945	24	1945
25	V	26	Insurance		Glen Health and Home Management, Inc.	A	2,222	2,222	25	2222
26	V	30	Depreciation		Glen Health and Home Management, Inc.	A	31,319	31,319	26	31319
27	V	32	Interest		Glen Health and Home Management, Inc.	A	33,340	33,340	27	33340
28	V	33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	11,961	11,961	28	11961
29	V	35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	9,902	9,902	29	9902
30	V	24	Travel		Glen Health and Home Management, Inc.	A	1,644	1,644	30	1644
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 331,389			$ 242,643	$ * (88,746)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$ 1,062,500	GlenBar Management Company, Ltd.	B	$	$ (1,062,500)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,062,500			$	$ * (1,062,500)	39

Sum_6B

-1062500

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	21	Clerical	$	GlenShire Real Estate & Development Limited Partnership	C	$ 1,071	$ 1,071	15	1071
16	V	19	Bank Fees		GlenShire Real Estate & Development Limited Partnership	C	1,000	1,000	16	1000
17	V	30	Depreciation		GlenShire Real Estate & Development Limited Partnership	C	480,336	480,336	17	480336
18	V	32	Interest Income		GlenShire Real Estate & Development Limited Partnership	C	(47,429)	(47,429)	18	-47429
19	V	32	Interest Expense		GlenShire Real Estate & Development Limited Partnership	C	918,991	918,991	19	918991
20	V	33	Real Estate Taxes		GlenShire Real Estate & Development Limited Partnership	C	657,110	657,110	20	657110
21	V	34	Rental Income	2,338,300	GlenShire Real Estate & Development Limited Partnership	C		(2,338,300)	21	-2338300
22	V	32	Amortization of Mortgage Costs		GlenShire Real Estate & Development Limited Partnership	C	12,248	12,248	22	12248
23	V	36	Mortgage Insurance Premium		GlenShire Real Estate & Development Limited Partnership	C	59,329	59,329	23	59329
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 2,338,300			$ 2,082,656	$ * (255,644)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

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Print Page 6D

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Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

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Facility Name & ID Number Glenshire Nursing and Rehabilitation Centr # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sidney Glenner	President	Administrative	80.00 %	106,218	13	22.30 %	Salary	$ 28,782	Ln 17, Col 1	1
2	Barry Ray	Vice President	Administrative	20.00 %	79,664	9	22.30 %	Salary	21,587	Ln 17, Col 1	2
3	David Glenner	Vice President	Administrative	0.00 %	59,010	9	22.30 %	Salary	15,990	Ln 17, Col 1	3
4											4
5											5
6			See Schedule B								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 66,359		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Glen Health & Home Management, Inc.
Street Address: 5454 West Fargo
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 674-5454
Fax Number: (847) 674-8311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	5	Utilities	Patient Days	419,697	5	37,338		89,491	7,961	2
3	6	Repairs and Maintenance	Patient Days	419,697	5	68,287		89,491	14,561	3
4	19	Professional Fees	Patient Days	419,697	5	141,688		89,491	30,212	4
5	20	Licenses, Permits and Inspections	Patient Days	419,697	5	8,563		89,491	1,826	5
6	21	Clerical	Patient Days	419,697	5	180,270		89,491	38,439	6
7	22	Employee Benefits and Payroll	Patient Days	419,697	5	264,051		89,491	56,303	7
8	23	Training and Education	Patient Days	419,697	5	3,079		89,491	657	8
9	32	Amortization of Mortgage Cost	Patient Days	419,697	5	1,646		89,491	351	9
10	25	Auto Expenses	Patient Days	419,697	5	9,121		89,491	1,945	10
11	26	Insurance	Patient Days	419,697	5	10,420		89,491	2,222	11
12	30	Depreciation	Patient Days	419,697	5	146,881		89,491	31,319	12
13	32	Interest	Patient Days	419,697	5	156,358		89,491	33,340	13
14	33	Real Estate Taxes	Patient Days	419,697	5	56,094		89,491	11,961	14
15	35	Equipment and Vehicle Rental	Patient Days	419,697	5	46,437		89,491	9,902	15
16	24	Travel	Patient Days	419,697	5	7,709		89,491	1,644	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,137,942	$		$ 242,643	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Maryland Mortgage Corp.		X	Mortgage	$102,527.00	3/16/1996	$ 12,973,600	$ 11,714,189	04/01/2018	.0775	$ 918,991	1
2	First Maryland Mortgage Corp.		X	Amortization of mortgage costs							12,248	2
3							Mortgage interest allocated from Management Company:				33,691	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$102,527.00		$ 12,973,600	$ 11,714,189			$ 964,930	9
	B. Non-Facility Related*											
10									Interest Income Offset:		(102,112)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (102,112)	14
15	TOTALS (line 9+line14)						$ 12,973,600	$ 11,714,189			$ 862,818	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	662,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	648,110	2
3. Under or (over) accrual (line 2 minus line 1).	$	(13,890)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	671,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ____ For 19 ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	657,110	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	582,936	8
1996	601,797	9
1997	624,000	10
1998	642,858	11
1999	648,110	12

See Attached Schedule H For Calculation Of 2000 Real Estate Tax Accrual.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,624 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Four

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	146,800	1994	$ 300,792	1
2	Allocated from Management Company:			22,320	2
3	TOTALS	146,800		$ 323,112	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	294		1994	1981	$ 11,663,928	$	30	$ 388,798	$ 388,798	$ 2,656,783	4
5											5
6	Mgt Comp:				474,913			10,121	10,121		6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Building Improvements			1994	78,204	7,820	10	7,820		50,833	9
10	Building Improvements			1995	107,573	10,757	10	10,757		60,958	10
11	Custom built 3rd floor nurses station			1995	6,595	660	10	660		3,080	11
12	Time delay egress locks and keypad			1995	3,550	355	10	355		1,656	12
13	Chimney			1995	1,016	102	10	102		476	13
14	Wall bumpers			1995	7,713	771	10	771		3,599	14
15	Room conversion - remodeling cost			1996	7,024	702	10	702		3,276	15
16	Electrical outlets and circuits			1997	18,500	1,850	10	1,850		6,783	16
17	Electrical outlets and circuits - dialysis room			1997	2,950	295	10	295		1,082	17
18	Air cleaner			1997	1,375	138	10	138		504	18
19	Fluorescent and incandescent lights			1997	9,775	978	10	978		3,584	19
20	Waste removal pump			1997	993	99	10	99		364	20
21	Boiler			1997	3,169	317	10	317		1,162	21
22	Food freezer floor			1997	2,700	270	10	270		720	22
23	New elevator clutch assembly			1997	1,644	164	10	164		438	23
24	Heat exchange for boiler			1997	2,392	239	10	239		638	24
25	Gazebo			1998	10,528	1,053	10	1,053		2,807	25
26	Fire sprinkler system repairs			1998	1,604	160	10	160		428	26
27	Security system			1998	1,917	192	10	192		511	27
28	Storage tank			1998	4,875	488	10	488		1,300	28
29	Elevator repairs			1998	2,706	271	10	271		722	29
30	HVAC replacements			1998	3,855	386	10	386		1,028	30
31	Hydraulic repack on all elevators			1998	2,500	250	10	250		667	31
32	Replace water heater			1998	2,697	270	10	270		719	32
33	Chain link fencing			1998	2,010	201	10	201		536	33
34	Elevator repairs			1998	2,747	275	10	275		733	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 29,063		$ 427,982	$ 398,919	$ 2,805,387	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Therapy room remodeling: drywall, electrical closet, piping			1998	8,525	853	10	853		1,421	9
10	Dialysis room: kitchen area			1998	2,757	276	10	276		459	10
11	10-B label fire rated doors			1999	4,376	438	10	438		730	11
12	Install cooling units in elevator and MDS office			1999	11,649	583	10	583		1,263	12
13	Mini-blinds			1998	1,565	157	10	157		417	13
14	November 30, 1998 credit			1998	(1,755)	(176)	10	(176)		(293)	14
15	Add suction & liquid filters to compressor			2000	3,982	199	10	199		199	15
16	Replace wood fence			2000	2,300	115	10	115		115	16
17	Asphalt & striping project			2000	8,365	418	10	418		418	17
18	Metal doors, install lighting by staircase			2000	6,010	301	10	301		301	18
19	Install alarm with keypad at front door			2000	1,177	59	10	59		59	19
20	Furnish & install 9,000 BTU mini air-conditioner system			2000	2,200	110	10	110		110	20
21	Install ceramic tiles			2000	1,373	69	10	69		69	21
22											22
23											23
24											24
25	Allocated from Management Company-See Attached Detail Schedule				1,116						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 3,402		$ 3,402	$	$ 5,268	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,322,926	$ 134,065	$ 134,065	$	5,10 years	$ 802,422	37
38	Current Year Purchases	8,869	444	444		10 years	444	38
39	Fully Depreciated Assets	0	0	0			0	39
40	Allocated from Mgt. Comp:	169,758		15,105	15,105		61,395	40
41	TOTALS	$ 1,501,553	$ 134,509	$ 149,614	$ 15,105		$ 864,261	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Allocation from Management Company:			$ 14,951	$	$ 2,856	$ 2,856		$ 11,681	42
43										43
44										44
45										45
46	TOTALS			$ 14,951	$	$ 2,856	$ 2,856		$ 11,681	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 166,974	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 583,854	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 416,880	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,686,597	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 13,094 Description: Copier $7,920, Ice-maker $2,392, Postage meter $711, Mgt. Co $2,071
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Management Company:		$	$ 7,830	17
18					18
19					19
20					20
21	TOTAL		$	$ 7,830	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

* It is the policy of this facility to hire only certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln 10a,Col2&3	hrs	$	1,938	$ 79,465	$ 1,654	1,938	$ 81,119	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		260	10,668		260	10,668	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a,Col2&3	hrs		1,647	76,137	1,298	1,647	77,435	4
5	Physician Care		visits			240			240	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				194,020		194,020	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39, Col 2					89,248		89,248	12
13	Other (specify): Radiology&Laboratory	Ln 10a, Col 1 Ln 39, Col 3	5327 hrs	159,806		16,817			159,806 16,817	13
14	TOTAL			$ 159,806	3,845	$ 183,327	$ 286,220	3,845	$ 629,353	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 915,815	$ 1,929,687	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 642,000)	3,329,691	3,656,372	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,378	104,967	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	20,729	386,563	8
9	Other(specify): Employee Loans Receivable	5,900	5,900	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,357,513	$ 6,083,489	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		323,112	13
14	Buildings, at Historical Cost		12,138,841	14
15	Leasehold Improvements, at Historical Cost	339,848	344,252	15
16	Equipment, at Historical Cost	414,493	1,516,504	16
17	Accumulated Depreciation (book methods)	(331,033)	(3,686,597)	17
18	Deferred Charges		11,473	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	55,856	794,265	22
23	Other(specify): Mortgage Costs (Net)		266,627	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 479,164	$ 11,708,477	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,836,677	$ 17,791,966	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 44,380	$ 44,380	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,883	38,883	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,518	191,518	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,534	6,534	31
32	Accrued Real Estate Taxes(Sch.IX-B)		671,000	32
33	Accrued Interest Payable		75,654	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule E:	1,710,682	1,710,682	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,991,997	$ 2,738,651	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,714,189	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To Officers	2,240,000	2,240,000	43
44	Due To Prior Owners	202,860	202,860	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,442,860	$ 14,157,049	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,434,857	$ 16,895,700	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 401,820	$ 896,266	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,836,677	$ 17,791,966	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,211,372	1
2	Restatements (describe):		2
3	**Prior Period Adjustments:**	396,829	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,608,201	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,606,381)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,206,381)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 401,820	24 *

* Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,706,011	1
2	Discounts and Allowances for all Levels	(2,325,505)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,380,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	487,156	6
7	Oxygen	646,325	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,133,481	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	260,648	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	119,188	19
20	Radiology and X-Ray	4,908	20
21	Other Medical Services	776,917	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,161,661	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,683	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,683	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,730,331	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,986,764	31
32	Health Care	4,895,162	32
33	General Administration	3,177,726	33
	B. Capital Expense		
34	Ownership	2,428,214	34
	C. Ancillary Expense		
35	Special Cost Centers	687,878	35
36	Provider Participation Fee	160,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,336,712	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,606,381)	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,606,381)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,657	2,045	$ 49,320	$ 24.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	53,230	58,707	1,183,669	20.16	3
4	Licensed Practical Nurses	42,765	45,405	803,124	17.69	4
5	Nurse Aides & Orderlies	113,342	121,220	1,083,840	8.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,539	7,843	159,806	20.38	7
8	Rehab/Therapy Aides	243	243	1,947	8.01	8
9	Activity Director	2,256	2,546	24,533	9.64	9
10	Activity Assistants	14,947	16,363	121,025	7.40	10
11	Social Service Workers	6,363	6,881	68,008	9.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,580	42,969	343,633	8.00	15
16	Dishwashers					16
17	Maintenance Workers	8,401	9,153	100,339	10.96	17
18	Housekeepers	32,356	36,296	306,621	8.45	18
19	Laundry	19,430	21,282	171,589	8.06	19
20	Administrator	3,120	3,120	66,526	21.32	20
21	Assistant Administrator	1,524	1,607	22,792	14.18	21
22	Other Administrative	1,612	1,612	66,359	41.17	22
23	Office Manager					23
24	Clerical	16,506	18,054	408,394	22.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,198	4,577	42,517	9.29	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	6,374	6,879	96,581	14.04	33
34	TOTAL (lines 1 - 33)	376,443	406,802	$ 5,120,623 *	$ 12.59	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 24,943	Ln 1,Col 3	35
36	Medical Director	Monthly	19,250	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,500	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	1,494	Ln 11, Col 3	44
45	Social Service Consultant	132	5,316	Ln 12, Col 3	45
46	Other(specify)				46
47	Medical Librarian	56	2,310	Ln 10, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	222	$ 54,813		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,276	$ 38,197	Ln 10, Col 3	50
51	Licensed Practical Nurses	3,126	81,789	Ln 10, Col 3	51
52	Nurse Aides	9,395	180,940	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	13,797	$ 300,926		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sidney Glenner	Administrative	80.00%	$ 28,782
Barry Ray	Administrative	20.00%	21,587
David Glenner	Administrative	0.00%	15,990
Colleen Kamin	Administrator	0.00%	27,945
Stephen Budick	Administrator	0.00%	38,581
Dianne Johnson	Asst. Administrator	0.00%	22,792
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 155,677

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 1,393,889
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,393,889

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems	Computer	$ 5,780
American Express Tax Services	Accounting	57,600
Sachnoff & Weaver	Legal	32,284
Admiral Insurance Co.	Legal	1,494
Burke, Warren & MacKay	Legal	568
Guardian Ship	Legal	955
Personnel Planners	Unemployment Consulting	1,520
Frost, Ruttenberg & Rothblatt	Accounting	5,754
Littler Mendelson	Legal	61
The Weiss Group	401 K Consulting	1,079
Commitment Consulting	A/R Collections	11,263
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 118,358

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,961
Unemployment Compensation Insurance	50,369
FICA Taxes	371,438
Employee Health Insurance	164,656
Employee Meals	25,829
Illinois Municipal Retirement Fund (IMRF)*	
Union Health and Welfare	38,040
Uniform Allowance	2,142
Profit Sharing, 401K Match	43,781
Employee Appreciation, Gifts, Bonuses, Awards	7,956
Employee Vaccinations	1,568
Allocated from Management Company:	
See Attached Schedule D:	56,303
TOTAL (agree to Schedule V, line 22, col.8)	$ 836,043

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,724
Health Care Worker Background Check (Indicate # of checks performed 109)	763
Illinois Council on Long Term Care Dues	9,924
JCAH Accreditation Survey Fees	10,122
AHCA Link Network Subscription	1,650
Elevator Inspection Fees	270
Miscellaneous Dues, Fees & Subscriptions	270
Allocated from Management Company:	1,826
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,549

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	0
Seminar Expense	0
Allocated from Management Company:	1,644
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,644

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	April 1996	$ 20,224	3 years	$ 6,741	$ 6,741	$ 3,371	$	$	$	$	$	$
2	Repairs & Maintenanc	August 1996	4,401	3 years	1,467	1,467	1,100						
3	Repairs & Maintenanc	1997	43,244	3 years	7,207	14,415	14,415	7,207					
4	Repairs & Maintenanc	1998	5,362	3 years		894	1,787	1,787	894				
5	Painting & Decorating	1999	12,667	3 years			2,111	4,222	4,222	2,112			
6	Painting & Decorating	2000	5,094	3 years				849	1,698	1,698	849		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 90,992		$ 15,415	$ 23,517	$ 22,784	$ 14,065	$ 6,814	$ 3,810	$ 849	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glenshire Nursing and Rehabilitation Centre # 0039321 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $9,924**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,882** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **160,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,829** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview